RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CH. 301]

Health Maintenance Organizations

Statutory Authority

Under the Health Maintenance Organization Act (act) (40 P. S. §§ 1551—1567), the Insurance Commissioner (Commissioner) deletes § 301.42 (12), amends § 301.2 and adds Subchapter G at §§ 301.121—301.126.

Purpose

The purpose of these amendments is to implement several consumer protection measures to mitigate HMO insolvencies and to provide for other protection in the event of an HMO insolvency. The Commissioner's statutory authority to amend these regulations is derived from section 5.1(b)(2) of the act (40 P. S. § 1555.1(b)(2)) which outlines criteria utilized by the Commissioner to determine an HMO's ability to meet its financial obligations to subscribers.

Section 301.2 is amended to include several newly defined terms. Sections 301.121—301.126 have been added at Subchapter G. Section 301.121 increases the initial capitalization requirements for newly formed HMOs as well as HMOs currently in operation in this Commonwealth. In addition, this section requires that every operational HMO deposit $100,000 with the Commissioner to be utilized for administrative expenses in the event of the insolvency of the HMO. Section 301.121 replaces existing HMO capitalization requirements in § 301.41(12) which were insufficient to insure HMO solvency.

Section 301.122 prevents health care providers from seeking reimbursement from HMO subscribers in the event of an HMO insolvency by implementing hold harmless provisions, and § 301.123 provides for a continuation of subscriber benefits for enrollees receiving care from a health care provider in the event of an HMO insolvency.

Section 301.124 requires that if a provider terminates its agreement with an HMO to provide health care services, the provider shall give the HMO at least 60 days advance notice of the termination.

Section 301.125 provides for replacement coverage for subscribers of an insolvent HMO by requiring other health insurers to provide coverage to the subscribers of an insolvent HMO. Finally, § 301.126 provides the Commissioner with the discretion to appoint an advisory group with HMO expertise to provide recommendations regarding a plan of action for a financially impaired HMO.

These amendments closely pattern recently adopted amendments to the HMO Model Act of the National Association of Insurance Commissioners. In addition, the amendments were promulgated through a joint effort of the Insurance Department (Department) and the HMO industry in this Commonwealth through a joint Task Force appointed by the Commissioner.

Comments

These amendments were proposed at 21 Pa.B. 3004 (July 6, 1991) under section 5 of the Regulatory Review Act (71 P. S. § 745.5).

During the public comment period no comments were received from the Standing Committees.

The following comments were received on the issues identified:

1. *Distribution of Assets in the Event of an HMO Insolvency.*

The Pennsylvania Medical Society (PMS) and the Independent Regulatory Review Commission (IRRC) recommended that health care providers be placed ahead of general creditors in the order of distribution of assets of an insolvent HMO which is governed by section 544 of The Insurance Department Act of one thousand nine hundred and twenty-one (40 P. S. § 221.44). Currently, health care providers receive assets of insolvent HMOs under section 544(d) or claims of general creditors. The recommendation of PMS and IRRC would distribute assets to health care providers under section 544(c).

The distribution of assets of an insolvent HMO is clearly set forth by section 544 of The Insurance Department Act of one thousand nine hundred and twenty-one which prohibits the establishment of subclasses within any class of the order of distribution. The priorities for distribution of assets of an insolvent HMO to providers of health care cannot be altered through amendment to this regulation since the priorities are mandated by statute.

2. *Administrative Deposit—§ 301.121(f).*

This section requires that each HMO deposit $100,000 with the Commissioner to fund administrative costs incurred by the liquidator of an insolvent HMO. The Insurance Federation of Pennsylvania (IFP) recommended that the $100,000 deposit be increased to $300,000 as a lesser amount may be insufficient to fund administrative costs as a result of an HMO insolvency.

The Department believes that $100,000 is a sufficient depository requirement. In addition, the section requires HMOs to deposit at least $100,000 which provides the Commissioner with the discretion to require additional deposits if a need is recognized to do so.

3. *Hold Harmless Provisions—§ 301.122.*

Section 310.122 of the hold harmless provisions requires that a contract between an HMO and a participating provider include "language to the following effect" and then sets forth a recommended hold harmless provision.

The IFP has recommended that the word "language" be replaced with the word "provision" which clarifies that the hold harmless clause will not need to be identical to the language in the section but rather must bring to effect the suggested language. The Department agrees to amend the regulation in its final form to replace the word "language" with "provision."

The hold harmless section also states "this provision shall not prohibit collection of supplemental charges or copayments on the HMO's or provider's behalf made in accordance with the terms of the applicable agreement between the HMO and subscriber/enrollee." The Pennsylvania Medical Society and IRRC have commented and recommended language changes to this section.

In its comments, PMS points out that providers do not typically collect supplemental charges and copayments on behalf of the HMO, but normally keep these fees

consistent with the contract with the HMO. PMS recommends that the words "on the HMO's behalf" be deleted.

IRRC commented that, while it appears that supplemental charges and copayments should be collected on behalf of the HMO, it is not clear if this section permits providers to collect supplemental charges and copayments that they are entitled to receive from the subscriber. Therefore, IRRC recommended that this section be amended to state that this provision not preclude collection of supplemental charges on either the HMO's or provider's behalf made in accordance with the agreement between the HMO and provider.

The Department's position is that some contracts between HMOs and participating providers grant providers advance payments from the HMO so that, in some circumstances, supplemental charges and copayments are due to be returned to the HMO. The Department's intention is to maximize available assets in the event of the insolvency of an HMO. Therefore, this section is intended to have the supplemental charges and copayments returned to the liquidator of the HMO for asset maximization purposes. However, the Department does not intend to prevent providers from seeking copayments due them from subscribers in the event of insolvency.

As a result, the Department agrees to the language suggested by IRRC and has amended this section to read "this provision shall not prohibit collection of supplemental charges or copayments on the HMO's or provider's behalf made in accordance with the terms of the applicable agreement between the HMO and subscriber/enrollee."

4. *Continuation of Benefits Provisions—§ 301.123.*

Section 301.123 requires that HMOs implement plans to provide for continued subscriber benefits in the event an HMO is declared insolvent. HMOs can select among five alternatives, outlined in this section to provide for benefit continuation. The alternative chosen by the HMO must be approved by the Commissioner.

PMS and IRRC have raised concerns over subsection (b)(2) which indicates that an HMO can establish "provisions in provider contracts that obligate the provider to provide services for the duration of the period after the HMO's insolvency for which premium payment has been made and until the enrollee's discharge from the inpatient facility." PMS indicates that this provision places an unfair burden on providers as it is unclear when a provider is obligated to cease providing services to an HMO subscriber, particularly if the subscriber is in an inpatient facility. As such, a provider could be obligated to provide services beyond the date for which premiums have been paid according to PMS. IRRC has also suggested that this language be clarified to indicate that a provider is not obligated to continue to provide services beyond the date for which premium has been paid.

The Department believes that the intention of subsection (b)(2) is clearly set forth in subsection (a). This section indicates that continuation of benefits should occur "for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits." The provisions of this section are not intended to extend subscriber benefits or subscriber obligations beyond the provisions of subsection (a). Therefore, no change to the language in subsection (b)(2) is necessary as the intention of this subsection is clearly indicated by subsection (a).

5. *Notice of Provider Termination—§ 301.124.*

This section requires that an HMO provider contract require participating providers to give 60-day advance notice of termination. PMS has objected to the 60-day requirement indicating that it is excessive. PMS has suggested that 30 days should be sufficient.

The Department is disinclined to alter the requirement for 60-day advance notice of provider termination. This section is promulgated to implement measures to protect subscribers of HMOs generally and, particularly, in the event of an HMO's insolvency. Therefore, requiring 60-days notice of provider termination is an important consumer protection measure, particularly if an HMO is declared insolvent which may heighten subscriber concerns over continued care until alternative coverage is implemented.

6. *Replacement Coverage—§ 301.125.*

This section requires that, in the event of an insolvency of an HMO, other insurers who solicited insureds from a group shall offer coverage to those who were insured by the HMO at the same rates and with the same benefits which the insurer offered to others within the group.

The IFP recommends that this section be clarified so as to permit a replacement insurer to implement and utilize underwriting standards which it applied to others in a given group in offering replacement coverage to subscribers of an HMO.

The Department believes that this request cannot be implemented since the practice of individually underwriting group health insurance has been adjudicated before the Commissioner in *"Individual Underwriting of Group Health Coverage"*, Docket No. M89-07-03 (1990). This adjudication has been affirmed in *Insurance Federation of Pennsylvania v. Foster*, No. 1293 CD 1990. Therefore, the Insurance Federation's request for clarification will not be included in this section.

Fiscal Impact

Fiscal impacts on the private sector are described in § 301.121 and include increased capitalization requirements for both newly adopted and existing HMOs and a deposit requirement to be used in the event of an insolvency of an HMO. These impacts are outlined as follows:

—Existing HMOs = $1 million in capitalization ($250,000 per year for 4 years).

—Newly formed HMOs = $1.5 million in initial capitalization.

There are no fiscal impacts upon the general public, political subdivisions or the Commonwealth.

Paperwork

These amendments will result in a one-time increase in paperwork for the private sector since HMOs will have to include the hold harmless and continuation of benefit provisions outlined in §§ 301.122 and 301.123 in provider contracts. These contracts are approved by the Department of Health which currently reviews the contracts. There will be a minimum increase in paperwork for the Commonwealth but no impact upon political subdivisions or the general public.

Contact Person

The contact person is Kenneth C. Wolensky, Director, Office of Program Services, 1326 Strawberry Square, Harrisburg, Pa. 17120, (717) 787-4429.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), the agency submitted a copy of the notice of proposed rulemaking to IRRC and to the Chairpersons of the House Committee on Insurance and the Senate Committee on Banking and Insurance for review and comment. In compliance with section 5(b.1) of the Regulatory Review Act, the agency also provided IRRC and the Committees with copies of all comments received, as well as other documentation.

These final-form regulations were deemed approved by the House Insurance Committee and the Senate Banking and Insurance Committee on December 10, 1991. IRRC met on December 19, 1991, and disapproved the regulations, in accordance with section 5(c) of the Regulatory Review Act. Under section 7(a) of the Regulatory Review Act, on January 14, 1992, the Department notified the Governor, the Commission and the designated Standing Committees of the House and Senate of their intention to proceed with the regulations with revisions. IRRC met on February 5, 1992 and approved the revised regulations.

Findings

The Insurance Department finds that:

(1) Public notice of intention to amend the administrative regulations amended by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202), and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) The amendment of the regulations of the Insurance Department in the manner provided in this order is necessary and appropriate for the administration and enforcement of the authorizing statutes.

Order

The Insurance Department, acting under the authorizing statutes, orders that:

(a) The regulations of the Insurance Department, 31 Pa. Code Chapter 301, are amended by amending §§ 301.2 and 301.42 and adding §§ 301.121 and 301.123—301.126 to read as set forth at 21 Pa.B. 3004 (July 6, 1991) and by adding § 301.122 to read as set forth in Annex A.

(b) The Insurance Commissioner shall submit this order, 21 Pa.B. 3004 and Annex A to the Office of General Counsel and Office of Attorney General for approval as to form and legality as required by law.

(c) The Insurance Commissioner shall certify this order, 21 Pa.B. 3004 and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) This order shall take effect upon publication in the *Pennsylvania Bulletin*.

CONSTANCE B. FOSTER,
Insurance Commissioner

Fiscal Note: Fiscal Note 11-84 remains valid for the final adoption of the subject amendments.

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 22 Pa.B. 811 (February 22, 1992).)

Annex A

TITLE 31. INSURANCE

PART X. HEALTH MAINTENANCE ORGANIZATION

CHAPTER 301. HEALTH MAINTENANCE ORGANIZATION

Subchapter G. PROTECTION AGAINST INSOLVENCY

§ 301.122 Hold harmless.

A contract between an HMO and a participating provider of health care services shall include a provision to the following effect:

"(Provider) hereby agrees that in no event, including, but not limited to non-payment by the HMO, HMO insolvency or breach of this agreement, shall (Provider) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than HMO acting on their behalf for services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on the HMO's or provider's behalf made in accordance with the terms of the applicable agreement between the HMO and subscriber/enrollee.

"(Provider) further agrees that (1) the hold harmless provisions herein shall survive the termination of the (applicable Provider contract) regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

"Any modification, addition, or deletion to the provisions of this section shall become effective on a date no earlier than fifteen (15) days after the Secretary of Health has received written notice of such proposed changes."

[Pa.B. Doc. No. 92-469. Filed March 13, 1992, 9:00 a.m.]